FBMC
BENEFITS MANAGEMENT
PO BOX 10789 Tallahassee, Florida 32302-2789

RETIREE ENROLLMENT FORM
Plan Year 2014
July 1, 2013 - June 30, 2014

STATE OF WEST VIRGINIA
Mountaineer Retiree Benefits

PLEASE PRINT USING A BALLPOINT PEN.

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SOCIAL SECURITY #	EFFECTIVE DATE (First day of month)	Choose one: ☐ Pay by check (includes TIAA-CREF)* ☐ Deduct from CPRB Retirement check**

LAST NAME (RETIREE OR SURVIVING SPOUSE)	FIRST NAME (RETIREE OR SURVIVING SPOUSE)	MI

MAILING ADDRESS [STREET]				
CITY	STATE	ZIP	BIRTH DATE	☐ MALE ☐ FEMALE

HOME PHONE	☐ MARRIED ☐ SINGLE ☐ WIDOW/WIDOWER	E-MAIL

INSTRUCTIONS

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All retirees or surviving spouse must complete this application to enroll for coverage. Please complete the dependent information section if you select coverage that includes dependents. You do not need to complete the form if you wish to continue your current benefits without changes. However, if you choose to enroll or make changes, please mail the form to FBMC Benefits Management PO Box 10789 Tallahassee, Florida 32302-2789.

* If you choose to pay by check, you will receive premium coupons for you to mail in your monthly premium.

** If you choose deductions through CPRB, your check deduction will pay for the following month's premium. Example: June deduction will pay the July premium. You will receive premium coupons for you to mail in your monthly premium until CPRB deductions begin.

MOUNTAINEER RETIREE BENEFITS

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Indicate all benefits selections by entering the necessary information below. Dependent eligibility is limited to the same benefit categories and amounts selected by the Retiree. If you elect dependent coverage for any benefit, you must provide dependent information in Section 4 below.

KEEP COVERAGE	CANCEL COVERAGE	CHANGE COVERAGE	ADD COVERAGE	BENEFITS
☐	☐	☐	☐	**DELTA DENTAL** — CHOOSE ONE DENTAL OPTION: ☐ Dental Assistance ☐ Basic ☐ Enhanced — CHOOSE YOUR COVERAGE LEVEL: ☐ Retiree Only ☐ Retiree & Spouse* ☐ Retiree & Children* ☐ Retiree & Family*

MONTHLY RETIREE DELTA DENTAL RATES	Dental Assistance		Basic		Enhanced	
	Retiree Only	$10.46	Retiree Only	$17.95	Retiree Only	$29.85
	Retiree & Children	$20.97	Retiree & Children	$35.95	Retiree & Children	$59.71
	Retiree & Spouse	$23.39	Retiree & Spouse	$40.06	Retiree & Spouse	$69.33
	Retiree & Family	$33.95	Retiree & Family	$58.10	Retiree & Family	$99.04

KEEP COVERAGE	CANCEL COVERAGE	CHANGE COVERAGE	ADD COVERAGE	
☐	☐	☐	☐	**VISION** — CHOOSE ONE VISION OPTION: ☐ Full Service ☐ Exam Plus — CHOOSE YOUR COVERAGE LEVEL: ☐ Retiree Only ☐ Retiree & Family*

MONTHLY RETIREE VISION SERVICE PLAN RATES	Full Service plan		Exam Plus plan	
	Retiree Only	$9.49	Retiree Only	$1.59
	Retiree & Family	$23.07	Retiree & Family	$3.61

KEEP COVERAGE	CANCEL COVERAGE	CHANGE COVERAGE	ADD COVERAGE	
☐	☐	☐	☐	**EPIC HEARING SERVICE PLAN** — CHOOSE YOUR COVERAGE LEVEL: ☐ Retiree Only $1.75 ☐ Retiree & Spouse* $3.56 ☐ Retiree & Children* $2.60 ☐ Retiree & Family* $4.40

*IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

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DEPENDENT INFORMATION

DEPENDENT NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED		
				DENTAL	VISION	HEARING
	SPOUSE					

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed.
Participants in the TIAA-CREF retirement plan: I certify the preceeding benefit elections are correct and agree to remit payment to FBMC

RETIREE SIGNATURE	DATE SIGNED